



Performance Measurement Work Group Meeting

10/18/2017

Welcome to New Members

QBR

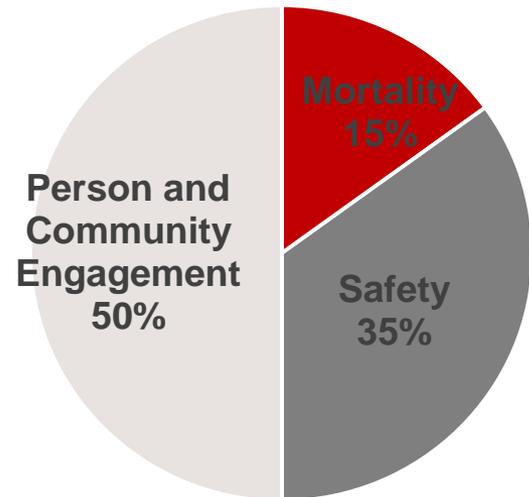
RY 2020 DRAFT QBR Policy Components

QBR Program – RY 2020 Snapshot

QBR Consists of 3 Domains:

- ▶ **Person and Community Engagement**
 - ▶ **(HCAHPS)** - 8 measures;
 - ▶ **ED Wait Times** – 2 measures;
- ▶ **Mortality** - 1 measure of in-patient mortality;
- ▶ **Safety** - 6 measures of in-patient Safety (infections, early elective delivery).

QBR Domain Weights



Up to 2% Reward or Penalty under QBR

Preset scale of 0-80 with cut point of 45

RX 2020 Proposed Timeline

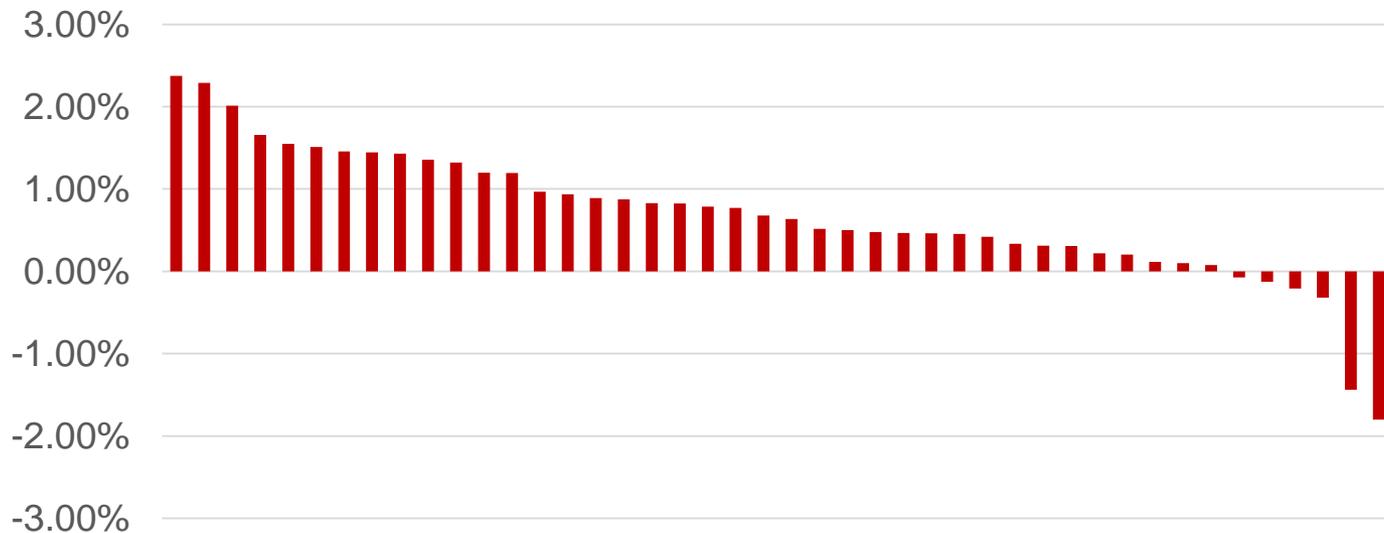
Rate Year (Maryland Fiscal Year)	FY16-Q3	FY16-Q4	FY17-Q1	FY17-Q2	FY17-Q3	FY17-Q4	FY18-Q1	FY18-Q2	FY18-Q3	FY18-Q4	FY19-Q1	FY19-Q2	FY19-Q3	FY19-Q4	FY20-Q1	FY20-Q2	FY20-Q3	FY20-Q4	
Calendar Year	CY16-Q1	CY16-Q2	CY16-Q3	CY16-Q4	CY17-Q1	CY17-Q2	CY17-Q3	CY17-Q4	CY18-Q1	CY18-Q2	CY18-Q3	CY18-Q4	CY19-Q1	CY19-Q2	CY19-Q3	CY19-Q4	CY20-Q1	CY20-Q2	
Quality Programs that Impact Rate Year 2020																			
QBR	Hospital Compare Base Period* (Proposed)																Rate Year Impacted by QBR Results (Missing are THA/TKA, ED Wait Times)		
								Hospital Compare Performance Period* (Proposed)											
			Maryland Mortality Base Period (Proposed)																
									QBR Maryland Mortality Performance Period (Proposed)										



* Hospital Compare measures currently include HCAHPS, NHSN Safety Measures, PC-01, ED Wait Times (Proposed)

RY 2018 MD Mortality

By Hospital Risk-Adjusted Survival Rate
Improvement
w/o Palliative Care



RY 2018 Statewide Unadjusted Survival Rates	FY 2015	CY 2016	Percent Change
w/o Palliative Care	97.68%	98.28%	0.62%
w Palliative Care	95.05%	95.33%	0.29%



RX 2020 MD Mortality

- ▶ Base Period: FY 2017
- ▶ Performance Period: CY 2018
- ▶ Move to single measure of in-hospital mortality (survival)
 - ▶ Discharges with palliative care included
 - ▶ 80% of APR-DRGs selected including palliative care
 - ▶ Regression model risk adjusts for palliative care diagnosis

Considering ED Wait Times – Oct Commission Meeting

- ▶ **Commissioner and Stakeholder Feedback:**
 - ▶ Support for continued focus on HCAHPS improvement
 - ▶ Mixed support of ED Wait Time measure inclusion
 - ▶ Need greater understanding of the drivers and opportunities for improvement
 - ▶ ED Wait Times are important patient experience and patient safety issue
 - ▶ Explore alternatives for addressing ED efficiency
- ▶ **HSCRC Next Steps:**
 - ▶ With Commission agreement, staff plans to include ED measures in RY 2020 QBR draft policy recommendation
 - ▶ HSCRC will model improvement for ED measures as part of person and community engagement domain
 - ▶ Will continue to work with performance measurement workgroup to refine draft policy recommendation

RY 2020 Person and Community Engagement – ED Wait Times Modeling

- ▶ ED Wait Times measures are included in Person and Community Engagement (HCAHPS) domain
 - ▶ Measures are weighted equally with other 8 HCAHPS measures, 0-10 points are possible
- ▶ Hospitals receive 0-9 points for improvement from base period, or 10 points if more efficient than national median in performance period

RY 2020 Person and Community Engagement – ED Wait Times Modeling

- ▶ HSCRC and Contractors MPR have modeled inclusion of **ED-1b** and **ED-2b** measures, stratified by Hospital Volume Category*, compared to national medians by volume
- ▶ Protections:
 - ▶ Hospitals that improved (received score greater than 0) will receive better of QBR score with or without ED measure(s)
 - ▶ Hospitals at or below national median (more efficient) in performance period will receive full 10 points on ED measure

RY 2020 – ED Wait Times Modeling Results

- ▶ Please see **Handout** for by-hospital detail.
- ▶ If ED wait times (using RY 2018 data) were included in RY 2020 QBR:
 - ▶ 26 hospitals would have a lower score (average -.017 lower);
 - ▶ 1 hospital would have the same score (protected);
 - ▶ 17 hospitals would have a higher score (average .028 higher).

QBR Methodology: Scaling Rewards and Penalties (RY 2019)

A **preset scale** (established using full range of QBR potential scores) is used to determine hospital rewards and penalties; hospitals that score below the **target of 0.45** will receive a penalty; and those that score above will receive a reward.

Maximum rewards are increased to 2.00%.

	Final QBR Score	Below/Above State Quality Target
Scores less than or equal to	0.00	-2.00%
	0.15	-1.33%
	0.30	-0.67%
	0.40	-0.22%
Penalty/Reward cut-point	0.45	0.00%
	0.50	0.29%
	0.55	0.57%
	0.60	0.86%
	0.70	1.43%
Scores greater than or equal to	0.80	2.00%
Penalty/Reward cut-point:		0.45

R.Y. 2020 Scaling – Modeled Impact

- ▶ Full distribution of scores 0 – 80%, with cut-point at 45%.
- ▶ **Model A:** R.Y. 2018 Scores with R.Y. 2019 Preset Scale
- ▶ **Model B:** R.Y. 2018 Data with R.Y. 2020 Measures
- ▶ **Model C:** R.Y. 2018 Data with R.Y. 2020 measures and ED Modeling

	Model A	Model B	Model C
Statewide Penalty	-\$ 43,721,499.00	-\$ 47,416,062.00	-\$ 49,111,660.00
Statewide Reward	\$ 2,858,425.00	\$ 2,399,839.00	\$ 2,174,011.00
Statewide Total Impact	-\$ 40,863,074.00	-\$ 45,016,223.00	-\$46,937,649.00

Population Health under TCOC Model

Introduction and Overview

Enhanced Total Cost of Care Model

- ▶ State is currently negotiating a “Enhanced” or “Total Cost of Care” Model with the Centers for Medicare and Medicaid Services (CMS) to focus on the Medicare total cost of care
 - ▶ Expands efforts for delivery system transformation beyond hospitals
 - ▶ Care Redesign (CCIP and HCIP)
 - ▶ Maryland Primary Care Program (MDPCP)
 - ▶ Limits growth in total cost of care
 - ▶ Person-centered approaches to engage providers and consumers
 - ▶ Aligns Maryland’s clinical and public health resources to support providers improving population health for all Marylanders

Model Organization

Enhanced Total Cost of Care Model

-TCOC Savings
-Aggressive/Progressive Quality Measures
-Population Health Credits

Hospital
Programs/GB
R

Care
Redesign
Programs

Maryland
Primary
Care
Program

Potential
Future
Programs
(LTSS, Post-
Acute)

Maryland Primary Care Program (MDPCP)

- ▶ **Strengthens and transforms Primary Care Delivery by moving from volume to value**
 - ▶ Components include care managers, 24/7 access to advice, medication management, open-access scheduling, behavioral health integration, and social services
- ▶ **Complements and supports existing delivery system innovation in State**
 - ▶ Sustain the early gains of the All-Payer Model as targets become increasingly reliant on factors beyond the hospital

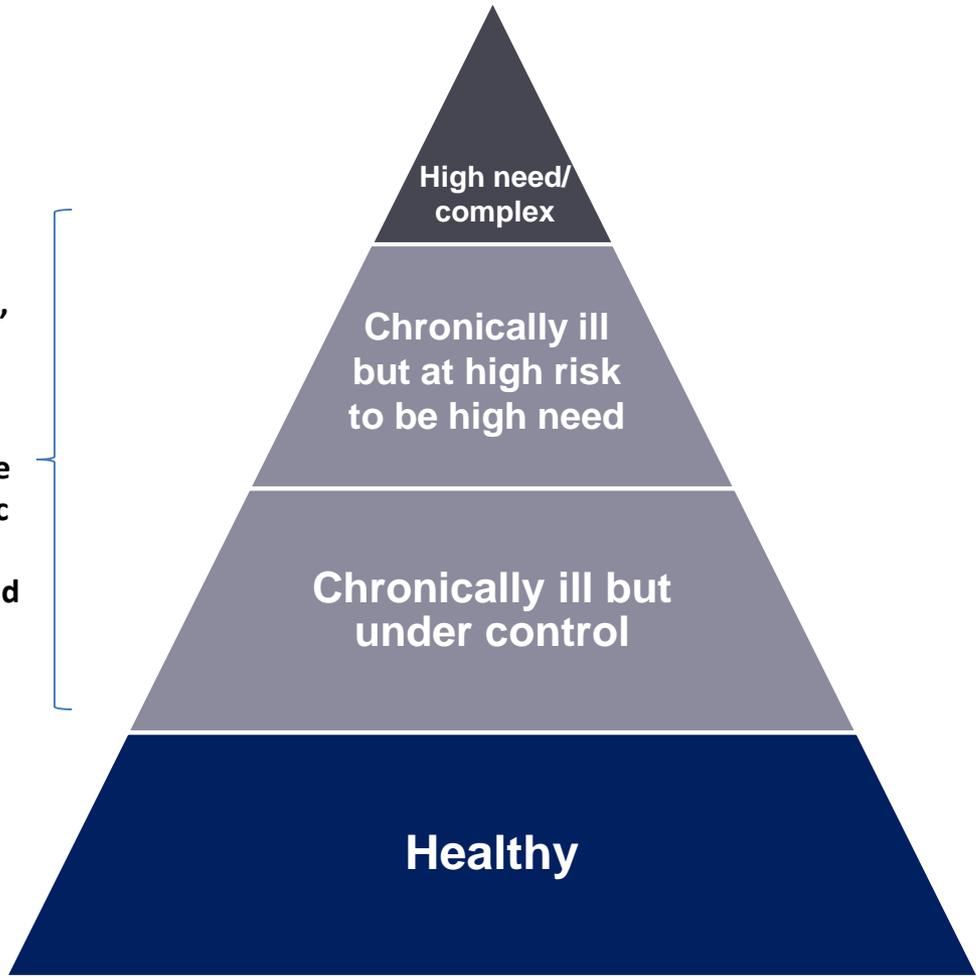
MDPCP Impact on TCOC

- ▶ Federal financial investment in building primary care infrastructure in Maryland.
- ▶ Impact on hospital global budgets
 - ▶ MDPCP expected to reduce avoidable hospitalizations and ED usage through advanced primary care access and prevention
- ▶ Reduction of disease prevalence crucial for long-term sustainability of the Model.
 - ▶ Recognition that reductions in prevalence are not immediately realized in hospital global budgets
 - ▶ Opportunity for Maryland to get credit for these long-term efforts

Core Approach— Person-Centered Care Tailored Based on Needs

B

Address modifiable risks and integrate and coordinate care, develop advanced patient-centered medical homes, primary care disease management, public health, and social service supports, and integrated specialty care



A

Care plans, support services, case management, new models, and other interventions for individuals with significant demands on health care resources (e.g., HCIP, CCIP)

C

Promote and maintain health (e.g., Maryland Primary Care Model)

Statewide Population Health

Population Health Opportunity – Broad Improvement Measures

- ▶ If the State can demonstrate improvements in all-payer, statewide population health measures, the federal government may reduce the MDPCCP Medicare dollars against Maryland's Medicare Total Cost of Care.
- ▶ Another route for achieving credit on TCOC and health status
- ▶ Components
 - ▶ Demonstrate improvement in population health
 - ▶ Assign a cost value to improvement in population health

Examples	Effect on Disease Prevalence	Effect on TCOC
System helps manage people with diabetes so fewer have complications	None - patients already have diabetes	Short Term Reduced hospital utilization, incentive payments to PCP
People with pre-diabetes lose weight and they do not progress to diabetes	Lowers or restricts growth in prevalence	Longer Term Control

Total Cost of Care (Enhanced) All-Payer Model

Programs: Primary Care Program, 2018-

Federal Government makes significant investment in Maryland Primary Care Program
+
State/stakeholders launch and expand population health initiatives

Measure: Population Health Goals assessed, 2019 – 2028+

State tracks population health measures based on negotiated measures and methodology to monetize prevention and improved management of population health measure – for example:

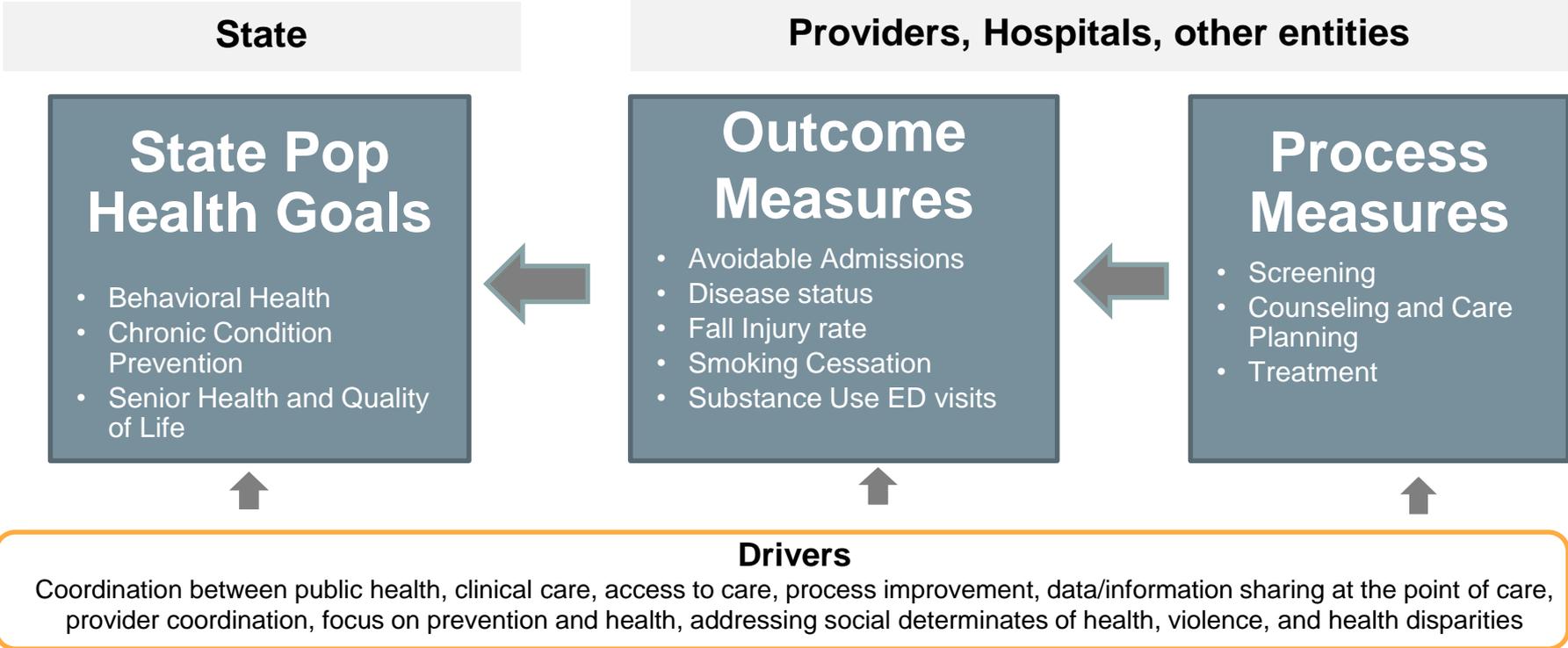
- Diabetes
- SUD/Opioids
- Others

Bonus: Outcomes-based Credit Awarded to State, 2024 – 2028+

If success in population health measures, Federal government awards financial credit to State's Total Cost of Care (TCOC) Model savings commitment. Credit is an offset against approved Federal Government investment in MD Primary Care Program.



Guiding Framework for Population Health



Timeline under the New Model

- ▶ State will submit at least one statewide measure with methodology for Population Health Credit by the end of 2017.
 - ▶ Anticipate approval of 1st measure – 2018
 - ▶ Other measures to be explored – 2018
 - ▶ Performance begins in 2019
 - ▶ Evaluation as early as 2023
- ▶ State will submit a plan for incorporating population health measures in hospital payments by Spring 2019.



PMWG's Role in Pop Health

- ▶ Inclusion of population health measures in Hospital Payment Programs
 - ▶ Through existing or new quality programs
 - ▶ Spring 2019 Proposal Population Health measures in Hospital payment
 - ▶ Need to align measures across different settings



Medicare Performance Adjustment

Within Context of Quality Performance

Medicare Performance Adjustment (MPA)

▶ **What is it?**

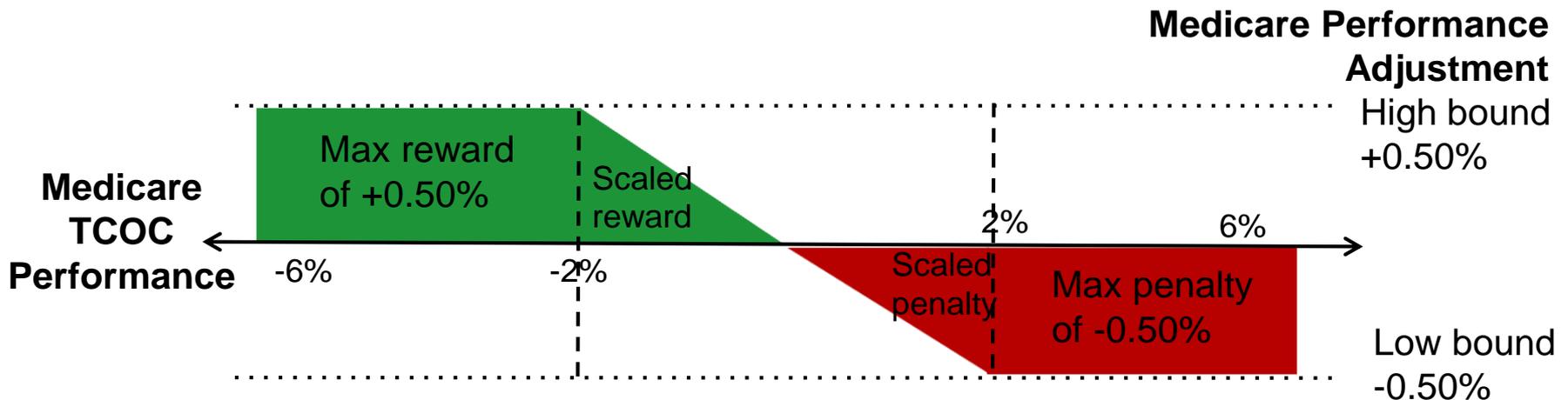
- ▶ A scaled adjustment for each hospital based on its performance relative to a Medicare Total Cost of Care (TCOC) benchmark
- ▶ Applied to Medicare FFS payments ONLY

▶ **Objectives**

- ▶ Allow Maryland to step progressively toward developing the systems and mechanisms to control TCOC, by increasing hospital-specific responsibility for Medicare TCOC (Part A & B) over time (Progression Plan Key Element 1b)
- ▶ Provide a vehicle that links non-hospital costs to the All-Payer Model, allowing participating clinicians to be eligible for bonuses under MACRA

RY 2020 MPA Scaling and Revenue at Risk

- ▶ Based on hospital's performance on the Medicare TCOC, the hospital will receive a scaled adjustment for RY 2020
- ▶ MPA will be applied to Medicare hospital spending, starting at 0.5% Medicare revenue at-risk (approx. 0.2% of hospital all-payer spending)
- ▶ CMS implements MPA % provided by HSCRC – applied to each hospital's federal Medicare payments in RY 2020
 - ▶ Not intended to go through rates



R_Y 2020 MPA Calculation

- ▶ Assess CY 2018 Performance compared to Benchmark (CY2017 Baseline + Trend Factor)
- ▶ Calculate initial MPA (Maximum Revenue at Risk: $\pm 0.5\%$)
- ▶ Apply quality adjustment to create final R_Y2020 MPA
 - ▶ At least 2 measures required per CMS
 - ▶ Final MPA cannot exceed $\pm 0.5\%$ Maximum Revenue at Risk

MPA Quality Adjustment

▶ RY2020

- ▶ Multiply the hospital's initial MPA by the hospital's RY19 quality adjustments for readmissions and hospital acquired conditions (accounting for negatives as appropriate)
- ▶ Moving forward, intention is to adjust based on population health metrics to align with the goals of the TCOC Model
 - ▶ Preventable Admissions/ED visits?
 - ▶ In-hospital screening for tobacco and BMI?
 - ▶ Referrals?

Complications Under the Enhanced Model – Update

Process Update: Complications under the Enhanced Model

- ▶ Enhanced Model continues to be negotiated – nothing final at this time.
- ▶ **General feedback Summary:**
 - ▶ Some support to moving to federal (national) complications measures
 - ▶ Some support for maintaining PPCs and paring down list to fewer, more clinically significant complications
 - ▶ Some concerns raised regarding risk adjustment under current MHAC methodology for RY 2020



Next Steps RE: Complications under the Enhanced Model

- ▶ HSCRC will re-visit complications under the Enhanced Model in 2018.
- ▶ Next Steps:
 - ▶ HSCRC plans to convene a sub-group of clinical experts in 2018 to build plan to measure and report complications under the Enhanced Model
 - ▶ Scope will include review of potential all-payer, clinically valid complication measures
 - ▶ Anticipated timeline:
 - ▶ Sub-group will meet beginning in early 2018
 - ▶ Sub-group will recommend measures to the PMWG by Summer 2018
 - ▶ PMWG to develop payment adjustment methodology Fall 2018



**Our next Performance Measurement
Work Group Meeting will take place on
Wednesday, November 15th at 9:30 AM**

Contact Information

Email: HSCRC.performance@Maryland.gov